Appendix A (COBRA)

Complete this *COBRA Continuation Coverage Election* form if the qualifying event is one of the following:

Employee:

- Employee's employment ends for any reason other than gross misconduct.
- Employee's hours of employment were reduced.

Spouse:

- Your spouse (the employee or retiree) dies; or
- Your spouse's (the employee's) hours of employment are reduced; or
- Your spouse's (the employee's) employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee or retiree) reduces or eliminates your Public Employees Benefits Board (PEBB) medical or dental coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Dependent child:

- Your parent (the employee or retiree) dies;
- Your parent's (the employee's) hours of employment are reduced;
- Your parent's (the employee's) employment ends for any reason other than his or her gross misconduct; or
- You stop being eligible for PEBB coverage as a "dependent child." (See WAC 182-12-260(3), (4), and (5).)

COBRA Continuation Coverage Election

Instructions

To elect COBRA coverage, complete this *COBRA Continuation Coverage Election* form and return it to PEBB Benefit Services.

Mail to:
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Hand-deliver to:
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

To elect COBRA, you must complete the *COBRA Continuation Coverage Election* form in this Appendix A, and submit it to PEBB Benefit Services. Under federal law, you have **60 days** after the postmarked date of this *Continuation of Coverage Election Notice* to decide whether you want to elect COBRA.

The *COBRA Continuation Coverage Election* form must be completed and either mailed or hand-delivered to PEBB Benefit Services at the address specified in this notice. **Oral communications (in person or by telephone) and electronic communications (fax or e-mail) are not acceptable methods of elections, and will not preserve your COBRA rights.**

If you do not submit a completed *COBRA Continuation Coverage Election* form by this due date, you will lose your right to elect COBRA or other continuation coverage.

Read the important information about your rights in the *Continuation of Coverage Election Notice* which includes this *COBRA Continuation Coverage Election* form.

Public Employees Benefits Board (PEBB)

2006 COBRA Continuation Coverage Election

• Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

• Make checks payable to the State Treasurer.

Employee/Retiree Information ONLY	Employee/retiree name	
	Employee/retiree social security number	Date employer or retiree coverage ended (mm/dd/yyyy)

I/we elect COBRA continuation coverage as indicated below:

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ☐M ☐F	Last name	First name	Middle initial

Address Apt./unit number

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code. ➡ Physician or clinic code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason**_____ **Date of qualifying event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **attach a copy** of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?* Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Section 2: SPOUSE INFORMATION

*List **only** eligible family members.*

Social security number	Date of marriage (mm/dd/yyyy)	Physician or clinic code	Sex ☐M ☐F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

Dependents of a retiree may choose medical/dental or medical only coverage.

☐ **Cancel all coverage** **Reason**_____ **Date of qualifying event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **attach a copy** of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?* Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Section 3: FAMILY MEMBER INFORMATION

(Such as child, grandchild, etc.) ***Use additional forms for more members.*** *List* ***only*** *eligible family members.*

A

Relationship to subscriber	Social security number	Physician or clinic code	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Sex ☐ M ☐ F

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only Dependents of a retiree may choose medical/dental or medical only coverage.

☐ **Cancel all coverage** **Reason** _____ **Date of qualifying event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **attach a copy** of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?* Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

B

Relationship to subscriber	Social security number	Physician or clinic code	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Sex ☐ M ☐ F

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only Dependents of a retiree may choose medical/dental or medical only coverage.

☐ **Cancel all coverage** **Reason** _____ **Date of qualifying event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No Effective date _____

If yes, **attach a copy** of your Social Security Disability Award letter.

Are you enrolled in Part(s) A and/or B of Medicare?* Part A (hospital) ☐ Yes ☐ No Effective date _____

Part B (medical) ☐ Yes ☐ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Section 4: MEDICAL PLAN SELECTION

(Check only one.)

- ☐ Community Health Plan of Washington*
- ☐ Group Health Cooperative*
- ☐ Group Health Options, Inc.*
- ☐ Kaiser Foundation Health Plan of the Northwest
- ☐ PacifiCare of Washington, Inc.*
- ☐ Regence BlueShield*
- ☐ UMP Neighborhood*
- ☐ Uniform Medical Plan PPO

These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.

Section 5: DENTAL PLAN SELECTION

(Check only one.)

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: **Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.**

Section 6: SIGNATURE (Required)

I/we have received and read this entire *Continuation of Coverage Election Notice* including any appendices. I/we understand that insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief the individuals listed on this election form are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if it is determined that individuals electing coverage are ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Signature _____ Be sure to sign this form after printing _____ Date _____

Relationship to individual(s) listed on form _____ Daytime phone number _____